Safeguarding Adults Review

‘Sally’

Overview Report exploring multiple disadvantage and cuckooing

September 2024

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Glossary

AWP	Avon and Wiltshire Mental Health NHS Partnership
GWH	Great Western Hospital NHS Trust
ICT	Swindon Council's Initial Contact Team for Adult Social Care
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Reviews
MARAC	Multi-agency Risk Management Conference (to address high risk domestic abuse)
LiFT	Talking therapeutic psychological services provided via GP
OCG	Organised Criminal Groups
PCLT	Primary care (mental health) liaison team
PPN	Public Protection Notification sent by police re safeguarding concerns
PTSD	Post Traumatic Stress Disorder
SAR	Safeguarding Adults Review
SBC	Swindon Borough Council
SDASS	Swindon Domestic Abuse Support Service
SIMS	Swindon Intensive Management Support (housing service)
SIS	Swindon Intensive Support (mental health service)
SSP	Swindon Safeguarding Partnership
SWAST	South Western Ambulance Service Trust

1. Introduction

1.1. Sally[1] was a white, British woman aged 48 when her body was discovered in her home. The home environment had high levels of clutter and signs of serious self-neglect. For many years prior to her death Sally was known to be at risk by several SSP partner agencies of exploitation, including cuckooing.[2] This report explores, through a SAR in Rapid Time methodology, the social and organisational factors that make it harder or easier for agencies to come together with an adult at risk to keep them safe. The focus is on system findings, to better understand what Sally's experiences can teach us about potential changes and improvements that could strengthen safeguarding system for other people who find themselves in similar circumstances to her.

1.2. On the 24.04.24 the SSP's Practice Review Group recognised this met the mandatory criteria for a Safeguarding Adults Review ['SAR'] under s44 because abuse and neglect were factors in Sally's death and there were opportunities for agencies to improve practice to prevent future deaths. The Terms of reference were agreed by the three statutory safeguarding partners on the 11.06.24 and Safeguarding Circle were appointed on the 13.06.24. The review was supported by SSP team and a panel made up of senior leaders from relevant agencies who met on the 25.06.24. The period under review is from January 2022 until February 2024 and the key lines of enquiry the review will explore are:

i. Were agency assessments carried out appropriately; were these shared across agencies and was practice consistent with making safeguarding personal and mental capacity act principles?
ii. How should the Safeguarding Partnership work more effectively with people who have difficulty engaging with statutory support or sit between many services?
iii. How adept is the system at addressing intersectionality of complex trauma, addiction, domestic abuse and exploitation over a significant period of time?
iv. Are practitioners confident to use local and national tools/ best practice briefings to work with people at risk of exploitation, especially cuckooing?

1.3. There are no criminal proceedings directly relating to Sally. An Inquest into her death is ongoing.

1.4. Sally's family were contacted by the partnership to advise them of this review. One of her adult children spoke with the Reviewer in July 2024 and eloquently spoke of the challenges Sally had faced, her ill health and the abuse that had featured in her life. The paternal grandparents of her younger children also offered to support the review. SSP and the reviewer are extremely grateful for their input, this has enabled a more rounded view of her needs and the complexities of supporting her. There was also a multi-agency discussion in with the practitioners who worked directly with Sally during the review period. The report has also drawn on findings from recent SSP focus groups with practitioners and experts by experience exploring local responses to self-neglect and exploitation.

2. Short summary of Sally's experiences

2.1. Sally was socially isolated, she had been adopted as a young child. Her family reported she had been a bubbly, happy child but '*went off the rails'* at around 13. She had her older children when she was 19-22 and they were later removed from her care. Around 2007 she was imprisoned for drug offences and settled in Swindon on release from prison. Her eldest child had limited contact with Sally, but not for the last 6 years. She remains close to Sally's adoptive parents and reports that Sally had been abusive to them, so they also had very little contact. Sally's younger children (from a subsequent relationship) are in the care of their paternal grandparents. Initially, her younger children did have limited contact, but this ended as Sally reportedly found it difficult to maintain due to her ill health.

[1] This is a pseudonym was chosen in consultation with her family to protect her anonymity and out of respect for her surviving children.
[2] This is a form of criminal exploitation when organised criminal groups [OCG] take over the homes of local adults that OCG members have identified as vulnerable. They do this either by coercion or by manipulation (defined locally as fake friends or mate crime). Often this is linked to supply of drugs across county lines.

2.2. Sally had several long-term significant health conditions.[3] Throughout the review period, she continued to report pain and an unstable appetite, in conversation with the reviewer her eldest child reported she struggled with her nutritional needs as didn't understand what she could safely eat to maintain her health. She was on a wide range of medication and was referred by her GP for specialist pain management support in November 2021. In May 2022 she was referred for Mental Health support and, whilst she had lost contact with the team, reported she had found their input beneficial. Sally had historically misused alcohol and drugs, though was not believed to require ongoing support to address addiction at the time of her death.

2.3. She was known to MARAC in Swindon between 2013-21 as a high-risk domestic abuse victim and low level of perpetrator risk. MARAC discussions as early as 2017 had recognised increased risk as the perpetrator (her ex-partner) was also noted as Sally's carer. Her eldest child reported she had experienced abusive relationships for most of her adult life, but that the level of physical and psychological abuse with her ex-partner was severe, they felt this had '*become her normal so couldn't break out of the situation, though friends and family told her it was abusive and even when her youngest children were removed from her care.*' Police records indicate there were 27 incidents between 2008-21 where she was reported as a victim and, from 2012- 23 a further 23 domestic incidents where her ex-partner made allegations of abuse against her. She had been offered IDVA support through Swindon Domestic Abuse Support Service [SDASS] in 2021, but did not return any calls.

2.4. From 2017 Police records had intelligence she may be experiencing exploitation as her mobility vehicle was being used by her 'carer' to deal drugs. She also reported in 2017 that she was being financially abused by her carer. The following year she reported to police a different carer was assisting her, police noted the carer was known as a violent offender. In 2018, police referred safeguarding concerns to Swindon Borough Council [SBC] due to the level of self-neglect, possibly linked to substance misuse and risks of exploitation. Her child reported that Sally told her, around 2017, she was moving to supported accommodation and that an occupational therapist was sorting this out. It does not appear from any case records held by partner agencies that Sally had requested this, but may have understood the move to ground floor accommodation would come with additional support.[4] Her tenancy, however, was for general needs housing. Her child felt this was a missed opportunity, as Sally had required support at the time of the move and felt this would have provided an extra-level of protection and daily support for her mother. There were further reports that acquaintances had taken her phone (2018 and 2021), taken house keys and refused to return these (2019), had stolen her bank card and withdrawn money without consent (2020) or taken more out than Sally had authorised (2 separate people in 2020). In 2021 police had reliable information that Sally's phone was linked to drug supply chains.

2.5. In March 2022 police arrested two men from her address and made a partial closure order[5] to safeguard her from further exploitation. In addition, they increased patrols in her area and completed several welfare checks at her address, though this support ended at her request.

2.6. In May 2022 her GP referred her to the Primary Care Liaison Service [PCLT], noting she had PTSD from previous domestic abuse and concerned her mental health was worsening. Her GP also asked for medication support from Avon and Wiltshire Mental Health NHS Partnership [AWP] but this referral was closed as Sally reportedly did not respond to an 'opt-in letter' from AWP's Swindon Intensive Service [SIS]. In June 2022 Sally contacted Swindon's Intensive Management Service [SIMS][6] for support to manage personal care, shopping and maintaining her home, she reported 'difficulty with her phone', but agreed with the SIMS worker to speak with the PCLT. During practitioner discussions her GP practice spoke of the pride Sally had taken in choosing a new kitchen when she first moved into the property and how pleased she had been when they requested support to assist her maintain her garden. They understood this was important to her.

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[3] These included double scoliosis, diagnosis of bowel cancer (received in 2011), history of asthma and fibromyalgia- a long-term condition that causes pain all over the body, muscle stiffness, problems sleeping and with mental processing.

[4] Panel members involved in this review explained it would not be the role of an occupational therapist to make arrangements for supported accommodation, this would normally involve the Council's housing and adult social care departments.

[5] This is a civil police power which prohibits anyone but the tenant from using the property.

[6] Service offered by SBC's housing dept for vulnerable tenants. This involves agreeing a plan with the tenant and regular visits to check on progress, but the process also could lead on to enforcement action if tenant remains in breach of tenancy conditions.

2.7. In July 2022 she was conveyed to hospital by SWAST for dehydration. She told SWAST she required carers but had been 'overlooked by the council'. Conversely, adult social care practitioners from SBC's Initial Contact Team reported to this review they had made several attempts to contact her to complete assessments, but that she had refused these. They and her GP practice accepted her past experience of social care interventions meant that she was resistant to social care's offer of support.

2.8. In early December 2022 Virgin media raised concerns to AWP after speaking with her. She subsequently confirmed she was ok, but was admitted to hospital in late December 2022 followings another overdose. Whilst in hospital she was seen by GWH's Mental Health Liaison team who completed a full assessment. She was re-referred to SIS and confirmed she would use crisis line if felt suicidal. The referral to SIS was subsequently closed in January 2023 as she had not responded to letters or phone contacts.

2.9. In March 2023 SWAST ambulance crew attended her home due to abdominal pain and diarrhoea. SWAST crew, concerned about her home circumstances, made fire safety referral.[7] In the same month, the pain consultant reviewed her care (despite her non-attendance) and advised her GP to reduce her high levels of opioid pain relief. They advised she may experience unpleasant withdrawal, but this wasn't dangerous and that codeine was likely causing constipation and exacerbating symptomatic abdominal pain. Her GP practice also made a re-referral for surgical review as a preventative measure given previous diagnosis of bowel cancer as she had not attended an earlier appointment in 2022.

2.10. In June 2023 she was taken to hospital by police following an assault in her home. She confirmed an associate had made threats to kill and physically assaulted her. She had been thrown from her bed to the floor, then onto a coffee table sustaining injuries to her leg. She also reported that he had previously stolen her phone and pain medication so she had no way to contact for assistance. Sally reported feeling fearful to return home. The A&E consultant at GWH recorded '*significant safeguarding concerns.. I do not feel the patient is safe to be discharged to her own home'*. Sally agreed for referral to SBC's safeguarding team, the police and Domestic Abuse support services. Unfortunately, the safeguarding concern to SBC was not submitted, though this did not prevent immediate action to reduce risks as the consultant completed a DASH risk assessment, contacted police (101, who agreed to pass Sally's contact details to the officer in charge so they could provide her with any update) and a Domestic Abuse support service (who offered to support Sally with safety planning despite this not strictly falling within their remit as the associate was not in a relative or intimate partner). The consultant also arranged for Sally to be accommodated in a health step-down bed (though medically fit for discharge) and contacted Sally's housing officer and Sally was able to arrange for her locks to be changed. The housing officer also agreed to provide Sally with a new phone. All of this was in line with good multi-agency safeguarding practice.

2.11. In November 2023 SWAST crew were called to Sally's friend's home as they were concerns she was unresponsive. Whilst they found no medical abnormalities, concerned about social issues they agreed to convey Sally home and notified police of her vulnerability to abuse. The crew contacted police, but were advised they would not respond as there had been no crime reported. The police were also contacted later that month by Sally's neighbours who raised concerns they had not seen her for a few days. She was later reported to be safe.

2.12. In December 2023 she was arrested for assaulting her ex-partner. This was graded medium risk with a low DASH score, and in accordance with policy not referred to MARAC. Whilst in custody there were no concerns raised regarding her mental health, but (as she was known to AWP services) arrangements were made for her to meet with Wiltshire's Liaison and Diversion Service. That service subsequently agreed with her to make a referral to the Nelson Trust. A worker from Nelson Trust visited her whilst in custody and she agreed to outreach support at her home. She explained to them that she did not have access to a phone, so they wrote to arrange appointment in January 2024. Later that month, they made telephone contact with her. She disclosed she hates where she lives due to bad memories, has a lot of health conditions which she doesn't feel like she's getting support for and that she was struggling for money and food. The Trust arranged to carry out an outreach appointment, but Sally later contacted to rearrange appointment due to ill health. A follow up welfare call was made in early February and repeated voicemails were left.

[7] This done due to public safety concerns despite her refusal to consent as she was smoking in untidy house and cooking on a portable stove, she stated smoke alarm wasn't working but had refused to allow fire service to provide new one.

2.13. In mid-February 2024 Sally called to say she was still feeling poorly and asked for support with food. Nelson Trust completed a Box of Hope referral for food parcels to be delivered to her address on a weekly basis for four weeks. On 20.02.24 Nelson Trust visited her property but there was no answer at her door, her phone was off, so they sent a text and made a subsequently welfare call on 26.02.24 which also went to voicemail.

2.14. On the 28.02.24 Police attended Sally's home in response a welfare concern raised by her housing officer. The officers used s17E powers to force entry and sadly found her deceased. The attending officers and a sergeant completed a thorough search of the property, confirming the door and windows had been locked from the inside and there was no sign of any forced entry (other than the force used by police to complete their welfare check) or any indication of that an assault had taken place. It was therefore reported as a non-suspicious sudden death. The following day Box of Hope raised concerns to Nelson Trust as, unlike previous times when they had delivered a food parcel (including the week before), they had not seen her. Nelson Trust attended her home that day to complete a welfare check. Prior to raising a welfare concern with the police, they contacted Great Western Hospital to ask if Sally had been admitted which she hadn't. On contacting the police (via 101) the police call handler reported Sally's housing officer had also raised concerns for her welfare the previous day. Nelson Trust reported to this review that their staff had noted the doors were padlocked from the outside, likely undertaken by police to secure the property the previous day.

3. National and local safeguarding adults policy context

3.1. Since 2015, s42 Care Act extended previous adult safeguarding policy expectations to 'alert' local authorities of any safeguarding risks. Now all 'relevant partners'[8] are expected to cooperate with the local authority in the exercise of their safeguarding function to prevent abuse and neglect, recognise, report and respond appropriately when abuse or neglect occurs. The Care and Support guidance also set clear safeguarding obligations for professionals, providers, commissioners, and regulators to meet expectations to work collaboratively in response to safeguarding concerns. That guidance, replicated locally within the safeguarding adults' policy, also specifies the type and nature of a range of harms sadly commonly experienced by adults with care and support needs.

3.2. In response to learning from earlier SARs, SSP and Swindon Borough Council's [SBC] have developed an online portal containing built in e-guidance to support professionals submit detailed concerns to assist the triage process. On receipt of a concern via the portal SBC's initial contact team [ICT] reviews the information and, if found to meet the s42(1) criteria, ICT refers the matter to the Multi-Agency Safeguarding Hub [MASH]. The MASH includes SBC's social care, police and health colleagues[9] who are co-located within a secured office space. This arrangement ensures that, even where some partners (e.g. emergency responders) continue to follow an alert only safeguarding model, the three statutory safeguarding partners (police, SBC and ICB) retain shared responsibility for decision making via a daily virtual safeguarding hub meetings to discuss all new referrals. Under the current safeguarding adults policy there is also an expectation to consult the adult at risk and ensure the referrer is notified of decisions. Where s42(2) duties are triggered, a qualified social worker is appointed as an enquiry manager. Where MASH request another organisation lead on a caused enquiry (in line with powers under s42(2) Care Act), the duty enquiry manager contacts the relevant organisation and sets out in writing the expectations for that enquiry. They are then required to make further contact within 28 days to ensure the enquiry is progressing. In conversation with the reviewer, practitioners (including from voluntary sector) confirmed they were involved in decision making when they had raised concerns and felt confident to constructively challenge MASH or SBC colleagues if necessary. Voluntary sector colleagues understood that they might not be involved in protection planning or providing ongoing support in every case, as this required consent by the adult to their involvement, but one practitioner explained their service had implemented learning from Sally's case already to ensure they secured written consent at the first meeting so that statutory partners felt more comfortable in sharing information and involving them at the earliest opportunity.

[8] defined by s6(7) Care Act 2014 and including police, NHS bodies, the DWP, prisons and probation services.
[9] Health colleagues currently join virtually, though will be co-located once recruitment is completed.

3.3. The recent national SAR analysis report[10] identified 60% (n390) of SARs published between 2019-23 featured presentations of self-neglect. A further 5% (n33) explored criminal exploitation- both were features in Sally's case. A key improvement priority arising from the national report was for SARs to build on previously completed reviews, including those undertaken locally [priority 3]. It also highlighted the need for SAB and Community safety partnerships to draw closer links with specific risks for adults with care and support needs connected to county lines [priority 19]. Within that context it is important to note several themes have emerged from previous SARs undertaken by SSP since 2021 which are consistent with findings within the national SAR analysis, including:

- Professional curiosity when undertaking risk assessments.
- Poor engagement with multi-agency risk management processes
- Contested opinions on capacity, especially if substance misuse, self-neglect or coercion is a feature
- Difficulty operationalising trauma-informed approaches or applying the Making Safeguarding Personal principles in response to persistent risks or welfare concerns.

3.4. Two reviews recently completed by SSP (Kieran, 2021 and Terry, 2020) identified the adults had experienced exploitation in the years preceding their deaths. Too frequently the heightened risks of external coercion were conflated with persistent concerns that the adult wouldn't comply with treatment plans or refused support to address longstanding concerns regarding self-neglect and/or substance misuse. In 2023-4, in response to those reviews, SSP identified a need to tackle strategically all age exploitation and self-neglect. In respect of self-neglect, SSP support unit published **guidance**, conducted a professional survey and held showcase events. It now has a dedicated **webpage** collating useful information for practitioners seeking to support adults who self-neglect. In 2022 (during the earlier part of this review period), the support unit developed a **practice briefing** to support improvements to practice in response to adult exploitation and provided further **guidance** for professionals on their website.

4. Analysis

KLOE 1: Were agency assessments carried out appropriately; were these shared across agencies and was practice consistent with making safeguarding personal and mental capacity act principles?

4.1. Research findings into self-neglect and/or substance abuse[11] warn against practitioners assuming adults are making a 'lifestyle choice' without further exploring the person's ability to protect themselves. This is important in the context of safeguarding functions because it is the 'ability to protect themselves' rather than the capacity to make decisions that is the basis for safeguarding legal duties under s42 Care Act 2014. This duty sits alongside a general duty to carry out all social care functions in a way that promotes an adult's wellbeing. The 'wellbeing principle'[12] includes a focus on personal dignity, choice and control, but there '*is no hierarchy, and all should be considered of equal importance when considering 'wellbeing' in the round*'.[13] As such, equal weight should be attributed to duties to protect health and against abuse or neglect. Ultimately, the duty to protect life (protected under article 2, Human Rights Act 1998) requires all public bodies to do whatever is within their legal powers to reduce risk where the risk to life is real and imminent.

4.2. The Care and Support guidance now advises '*self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.'*[14]

4.3. As noted above, there were examples prior to and throughout the review period of practitioners exercising professional curiosity and sharing information to ascertain Sally was at risk of self-neglect or self-harm/ suicide, for example:

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[10] Second National Analysis of Safeguarding adults Reviews (2024) Preston-Shoot et al, available at: https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2019-march-2023-executive-summary.
[11] For example, Bray, Orr and Preston-Shoot (2015) 'Serious case review findings on the challenges of self-neglect: Indicators of good practice' Journal of adult protection 17,2, 75-87
[12] S1 Care Act 2014
[13] Section 1.6 Care and Support Guidance, DHSC available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#general-responsibilities-and-universal-services
[14] Ibid, pg.14.17

- SWAST crew contact with family and GP to assess risk following reports of overdose in August 2021, following which they also raised a safeguarding concern to SBC regarding self-neglect and notified the named nurse for Sally's children of their concerns.
- Her admission and assessment by GWH's Mental Health Liaison Team in December 2022, following an overdose when she agreed to contact LiFT psychology, for a re-referral to Swindon Intensive Support [SIS] service and to use the crisis line.
- SWAST decision to refer for fire safety advice on public safety grounds (March 23) and returning her home after altercation with 'friend' (Nov. 23)
- Virgin media raising concerns[15] (Dec. 2022) and neighbours alerting statutory partners of their concerns about her wellbeing (Nov. 2023).
- Wiltshire Liaison and Diversion service referral to Nelson Trust to address self-neglect concerns (Dec. 2023)
- Nelson Trust's frequent contact to check of welfare, arranging Box of Hope to support her to access food and escalating to police when concerned for safety (Jan-Feb '24).

4.4. The local SSP multi-agency policy and practice guidance to address self-neglect concerns encourages practitioners to hold multi-agency meetings and sets out the key agencies roles and responsibilities. During the practitioner discussions, GP practice staff spoke of their confidence to call such multi-agency meetings, but explained often they receive inadequate responses from statutory partners. This may be due to high demand for these service, but also because self-neglect does not always naturally fit to clinical pathways or social care task orientated outcomes or support provision. Where the person is not already known to social care, requests to attend meetings are triaged by SBC's Initial Contact team by a duty worker. They will try to contact the person to understand how they could support such meetings, but report doing so in a meaningful way whilst managing the duty calls for each day is difficult particularly if the person has additional communication needs associated with long-term trauma and/or addiction. Frontline Police and SWAST staff at the practitioner event explained they were not aware of the expectation to call for a multi-agency meeting for self-neglect and would not be expected to attend such meetings, rather their internal safeguarding policies require they recognise and report via current s42 processes (including PPN notifications from frontline police officers) any concerns. None of the practitioners understood how they could report (within their own organisations or across partners) on the outcomes of such meetings.

4.5. Sally's safety and needs had been discussed many times within the multi-agency discussions at MARAC between 2013-21. MARAC identified the risks associated with Sally's inability to meet her daily living needs and the heightened risks of her dependency on the perpetrator for daily care. It was noted that adult social care would need to complete an assessment, but that they have difficulty engaging with her. IDVA support was also offered, but was not taken up by Sally. These discussions took place prior to the period under review. It is important to note also Sally did not raise concerns of domestic abuse though she was arrested (in December 2023) for perpetrating abuse against a partner. That said, from the information available, there appeared to be little change in Sally's circumstances such that her status as a high-risk domestic abuse victim could still have applied. Historically MARAC did not have a process for tracking actions to be completed, but this has now been introduced. However, they remain reliant of police and other partner agencies to refer cases, having completed assessments and deemed cases high risk. The police confirmed they refer concerns to MARAC even if they do not reach high risk threshold whenever there are 5 domestic abuse incidents within 12 months.[16] GWH confirmed that high risk domestic abuse flags are removed from their electronic records after 12 months. Whilst they are still able to access archived information, it would not automatically alert someone to an ongoing risk. It does not appear from the MARAC records that agencies were satisfied in 2021 that the risks had been addressed. Sally had not engaged with any support offered, but this was not escalated across partners for a shared risk plan.

4.6. During and before the review period, Sally did disclose threats from people who misused access to her bank card, keys or phone. She also contacted police to report an assault. In response, agencies shared concerns regarding Sally's vulnerability to abuse and exploitation, including cuckooing. There

[15] Family involved in the review wished to commend Virgin staff. They explained that, following her death, they became aware she was in debt to utility companies and that (unlike the positive approach adopted by Virgin) many had proceeded directly to debt recovery agencies without regard to the distress this may have caused Sally.

[16] Safelives recommended concerns should be raised after 3 incidents which required police attendance within the pre-ceding 12 months. However Wilshire police have indicated they do not have resource to implement this currently. It may be that SSP partners would want to explore if this could be actions by the adult MASH if three PPNs are received in respect of adults with care and support needs.

are good practice examples of agencies taking steps to safeguard her from imminent risk in response to those risks, including:

- Police arrests and use of partial closure powers in 2022 in response to County lines criminal exploitation which included a wider vulnerability plan so her wellbeing was monitored for a time by police until she requested this end.
- Her admission into a step-down bed due to safety concerns in June 2023 following an assault by an associate at her home, including supporting her to call her housing officer to change her locks. The GWH A&E staff also referred the matter to the police and to SDASS.

However, her longer-term needs, including to manage her activities of daily living and therapeutic support to resolve her PTSD remained unaddressed.

4.7. There were also examples within the Individual Management Reports [IMR] of good practice in recording Sally's views and of Sally providing assurance to emergency responders to allay their safeguarding concerns (e.g. in December 2022 in response to Virgin Media's concerns). For example, the police's IMR commended their officers for completing PPN and a vulnerability risk assessment with her. Her GP also reported seeking views from a range of professionals within the surgery and recording these on her notes. They also provided rationale for decisions which appeared to go against Sally's wishes, e.g. in light of her history of overdose, refusing her request for increases in medication demonstrated preventative safeguarding action. SWAST IMR highlighted the multi-agency liaison carried out by crew as good preventative practice and the decision to refer for a fire safety check, despite Sally's reluctance demonstrated careful balance of wider public safety issues. This is in line with Making Safeguarding Personal principles. There are also notable examples of good multi-agency practice, for example involvement of the Wilshire Liaison and Diversion service following her arrest in December 2023 who, despite concluding that she did not require ongoing support from their service referred her for support to the Nelson Trust. Nelson Trust also reported good practice with consistent and persistent checks on Sally, escalating their concerns to police when they were unable to get a response. Sadly, Sally passed away before they could work constructively with her to develop a support plan.

4.8. Sally also alerted agencies to her inability to manage her health, personal care and nutritional needs. Her mental health was assessed at three attendances at A&E following overdoses (17.08.21, 19.08.22 and 28.12.22), It was noted (in June 2022) that she needed reassurance throughout a call to SIMS (housing), but responded well to advice signposting her to the PCLS. However, consistent with previous offers of support following MARAC discussions, she did not follow up with that advice. She was also reviewed in A&E following a serious assault (27.06.23) and safeguarding concerns were identified also on the 17.11.23. It does not appear from any case records that a formal assessment was made of her mental capacity or shared with relevant partners on any of those occasions.

4.9. A recent audit of completed safeguarding enquiries exploring responses to self-neglect, domestic abuse and exploitation found very few of the cases audited had recorded an assessment of the adult's capacity. Whilst there is a presumption of capacity,[17] learning from two national SAR analysis reports continues to highlight how frequently (58% of cases) a lack of attention to mental capacity increases risks to adults with care and support needs and contributes to unsafe outcomes. Similarly, SSP's audit found limited evidence of risk removal. Risks were noted to remain more often where the concerns involved domestic abuse (including possible financial abuse/economic coercion) and the adult at risk did not support follow up from police and/or health, social care agencies. That audit found few safeguarding enquiries involved an assessment or review of the person's social care needs. This resonates with Sally's experiences.

4.10. Failure to consider the person's ability to keep themselves safe, or their ability to act on advice is particularly important where an adult has experienced trauma or been subject to coercive control, as Sally had been. This was also a feature in SSP's Summer and Brian SARs. Previously practitioners involved in focus groups have described feeling hindered by a lack of clear guidance, training or access to specialist clinical input to support their practice in such situations. They explained the 'usual capacity training' offered didn't address how to support an adult with cognitive impairments, neurodiversity or trauma recognise and report concerns/ abuse. It didn't provide practical guidance on working with adults with serious enduring mental disorders (including personality disorders or neurodiversity). They explained there was a lot of nuance and professional integrity required to weigh

[17] Under s1 Mental Capacity Act 2005

up safeguarding obligations within complex cases and that this was particularly crucial if the adult had expressed reluctance (as Sally had in 2022) for the police to investigate or for social care support.

4.11. Within their IMR Great Western Hospital [GWH] reported Sally had verbalise her situation and what she wanted to be different. They noted evidence of timely information sharing with the police and domestic abuse services. Within case records staff report submitting a safeguarding concern, but it appears this was not submitted to SBC. During discussions practitioners explained that SBC's e-guidance form can sometimes act as a barrier as it prevents completion of the referral if the referrer does not have all the information to evidence the s42 criteria is met. This will need urgently review (see recommendation 1), as the Care and Support guidance is clear agencies are expected to gather further information if necessary, rather than requiring the referrer to provide a complete picture.

4.12. There is evidence that, following the assault on the 27.06.23, police followed up and assessed Sally's vulnerability. She reported feeling scared and isolated and that she was experiencing PTSD. She reported fear of retribution and others in Swindon all of whom knew where she lived. Both the officer completing the risk assessment and the senior supervising officer graded this medium risk which indicated continued '*exposure to risk of harm if no additional response is provided by police or support given by partner agencies*'.[18] The officer referred the matter to the National Centre for Domestic Violence [NCDV], her GP and the hospital and signposted her for counselling. The officer also updated guidance for future responses, advising they should prioritise Sally's protection and take positive action (including arrest and securing evidence for prosecution). The offender was also set bail conditions intended to protect Sally and referred to the victim support service (Horizon). The officer, having completed a vulnerability risk assessment did not believe this met the criteria for a PPN to SBC (which may have triggered a safeguarding enquiry) but was satisfied she remained exposed to risk without additional support. Since this time Wiltshire police have rolled out further training on the 'three strands of vulnerability'[19]. Under this guidance, frontline staff who have (as the officer had here) identified a crime or anti-social behaviour against a vulnerable adult, are expected to 'investigate'. Whilst this does not require the officer to complete a PPN it does advise they contact social services directly and it is unclear why in this case that did not occur.

4.13. Her GP, reflecting on her clear vulnerabilities queried whether they should have completed a home visit following a reported burglary (after which Sally had stayed with a friend) to ascertain if earlier intervention support from a voluntary sector organisation may have assisted her. Swindon Domestic Abuse Support Service [SDASS] confirmed in their IMR that on receipt of the referral from GWH they confirmed with Sally and GWH staff that the assault had been by a friend rather than a family member so the referral was not appropriate. They offered to support the development of a safety plan, but this was not progressed when GWH confirmed, mistakenly, that a s42 safeguarding concern had been raised to SBC.

4.14. Likewise, SWAST IMR noted that in July 2022 the crew did not verify with SBC's social care if they were progressing an assessment of her care needs despite Sally commenting that she needed carers. In addition, crew did not make a referral in March 2023 despite concerns that Sally was not managing to maintain her home safely or meet basic needs, resulting in health and wellbeing deterioration. Also in November 2023 SWAST reported their concerns to the police, but not to SBC.

4.15. Previous focus group discussions stated it was also rare to secure longitudinal multi-agency involvement to monitor ongoing risk. This appears to be the case for Sally as the chronology suggests a reliance on emergency responders (police, ambulance crew, A&E staff) or her GP to address each incident with no obvious process to provide consistency or a longitudinal overview of the multiple disadvantages she was experiencing or how this might impact on her ability to stay safe. As such it appears to have frustrated agencies' ability to explore more closely what was preventing Sally from taking the actions she had previously agreed to during assessments. A clearer picture of her executive capacity may have enabled practitioners to intensify responses in a coordinated way.

System Findings

Sally mostly came to the attention of services at periods of crisis and through interventions led by emergency responders (police, SWAST crew, MHLT and GWH's A&E). There is evidence within these

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[18] Taken from the Police Vulnerability Risk Assessment

[19] The guidance is available here: https://www.wiltshire.police.uk/SysSiteAssets/foi-media/wiltshire/2022/11-november-2022/foi-2022-886_vulnerability-risk-assessment.pdf

incidents that responses were person-centred, practitioners considered Sally's views and sought to empower her to accept help. Formal capacity assessments were not recorded. However in line with expected safeguarding practice, emergency responders usually made follow up referrals, for example, in July 2023 Police also highlighted within their Vulnerability report that she would not be safe unless received support from police and/or partner agencies. The officer did make appropriate onward referrals, but not to SBC's adult social care.

In addition, there is evidence of good preventative interventions offered by Sally's GP practice staff, AWP's Liaison and Diversion Service, her neighbourhood housing officer and SIMS (housing) team and, in the final stages of her life, by Nelson's Trust and Hope Box staff.

However, opportunities to respond to direct requests for assistance by Sally did not trigger a 'team around the person' approach. For example, when she asked for additional support for her mental health, her GP practice and the SIMS (housing) team advised her to engage with AWP's SIS or PCLT. Whilst this is within acceptable referral pathways, better use of information held across partner agencies could have enabled a shared preventative plan via the self-neglect protocol with a multi-agency meeting.

There was not a lead agency identified to coordinate her considerable needs, including when referrals were made to AWP's teams, Housing's SIMS, SBC's ICT or concerns raised through the s42 process. Given the longevity of concerns, reported within MARAC minutes between 2013-21 and repeated unsuccessful attempts to engage Sally with proactive support (including IDVA, social care, SIS and LiFT's psychological support) throughout the review period, a more systematic approach would be to explore patterns in contact to understand if she lacked executive capacity to coordinate her own care and if she could stay safe without additional support. Currently the strategic oversight of the application of the self-neglect protocol is unclear. There is a lack of clarity for frontline practice across the partnership of when concerns should trigger assertive action either through the protocol or s42 processes. There is also no system-wide mechanism for tracking high risk cases where self-neglect is a feature or for SSP to have oversight to gain assurance that multi-agency interventions (outside the s42 process) are timely, person-centred and reduced risks for adults with care and support needs. Recommendations 1 and 3 relates to these findings.

KLOE 2: How should the Safeguarding Partnership work more effectively with people who have difficulty engaging with statutory support or sit between many services?

4.16. All IMRs submitted to this review identified frequent problems contacting Sally, both by letter or by phone. Both Sally and her GP requested secondary mental health support (in May and June 2022) in response to symptoms of PTSD, but this referral was closed when they did not get a response to an opt-in letter. It wasn't noted within any agency's records if Sally was literate.[20] In addition, Sally frequently reported her phone was not working and police intelligence reported her phone access was limited by those exploiting her to exert control. Importantly, this was not known by all agencies, her GP practice reported they were unaware and so would communicate via text or call her. So, despite an identified risk (given her status or high-risk domestic abuse victim (recorded in 2021) and as a victim of cuckooing in 2022) there was no agreed plan with her or across agencies as to how contact would be maintained or how she would access emergency support if at imminent risk of harm.

4.17. In addition to the practical issues of contact, Sally also had a long history of resistance to the welfare support offered by social services and safety measures offered by the police in response to the cuckooing and SDASS in response to domestic abuse. Her GP practice, AWP and GWH also reported numerous incidents when she did not attend appointments or respond to letters inviting her for assessments.

4.18. Practitioners who knew her were aware she had expressed discomfort with social care's involvement because she associated that offer with earlier social care interventions which had resulted in the removal of her children from her care. Social care practitioners spoke of support now offered to through New Beginnings or the Lifelong Links service to provide support for mothers who have had children removed from their care.

4.19. Her child remembered Sally as someone who was always very keen to maintain health appointments, including prioritising these over contact with them. This was also confirmed by her younger children's

[20] In conversation with the reviewer her younger children's grandparents confirmed she was literate and that she wrote poetry.

paternal grandparents. Gaining a system-wide understanding of her ability to engage with onward referrals to address her health conditions was made more difficult as there is currently no unified pathway to pick this up. Health partners, including GWH, will often come together to explore unmet need for 'frequent attenders' or frequent users of emergency responder services. Police PPN triage processes and, separately, SBC's safeguarding team may also identify those who come to notice repeatedly over a short period. Sally, however, rarely came to the same services attention at such a level to trigger any one partner to explore, collectively, if she had unmet needs or was at risk of abuse or neglect.

4.20. Instead, practitioners mitigated risks by seeking to ensure there was clear communication between primary care, SWAST and hospital-based clinicians regarding risks relating to her, including:

- Mental health: particularly during attendances when she disclosed taking an overdose (17.08.21 and 19.08.22 and 27-31.12.22). However, again the follow up offer of support from AWP's Swindon's Intensive Service [SIS] was withdrawn because of non-engagement (in January 2023).
- Safeguarding: clinicians considered safeguarding obligations, for example the A&E doctor contacting their safeguarding lead to raise concerns in June 2023 and arranging step-down provision despite being medically fit for discharge to protect against re-victimisation. Detailed information regarding the safeguarding concerns was forwarded to her GP, though not to SBC.
- Pain management: The consultant reviewed her presentations and providing advice to her GP noting that she was unable to attend (March 2023). GWH's IMR commented on the good forward plan for her GP to follow regarding pain management and reducing opioid medication to reduce risks associated with abdominal pain and constipation.

4.21. Within their IMR GWH reflected that, given her numerous chronic health conditions, health partners should take a more active role in preventing health deterioration rather than assume this will be managed by her GP. They expressed surprise that she was not known to their community nursing service, but community based health practitioners were clear that she would not have benefited from that service. Practitioners agreed that secondary health providers should have and socialise 'was not bought/ did not attend' policies to ensure adults with additional needs who miss appointments are reviewed to ascertain if the non-attendance reflects an inability to follow health/ treatment plan rather than treat this as 'dis-engagement' and consequently close a referral. They felt services such as LiFT or SIS should employ more assertive outreach given the nature of needs that are referred- often by GPs because the level of need required therapeutic evaluation and because they are without resources to offer assertive outreach.

4.22. Similarly her GP practice queried whether clearer guidance and an ability to 'flag' vulnerability and need for home visit after certain number of missed appointments or no responses from patients with history of trauma, domestic abuse or exploitation would enable primary care to play an increased role in identifying adults at risk. A few practitioners were aware (and complimentary) of the Live Well model being piloted within some local GP surgeries, reporting this offered real opportunity for better outcomes. No-one at the practitioner meeting was aware of the newly devised welfare and safety plans (developed by SSP's Adult Scrutineer Group) to support primary and secondary care coordinate care across different agencies and ensure any plan is devised with the adult.

4.23. Within discussions practitioners were keen to move away from circular referral routes, whereby concerned professionals raise concerns or requests for further assessment and support only to have these returned if the adult did not actively pursue the option to 'opt-in' to a service they had deemed necessary. They felt it would be important for such cases to be subject to more detailed multi-agency scrutiny to ensure partners could be satisfied that all available legal powers and wider offers of support (including from voluntary sector colleagues) had been considered before referrals are closed.

4.24. In the months preceding her death Sally had responded to support offered by Nelson's trusts more positively. In conversation with the reviewer, this service explained they work differently to statutory services, understanding that their clients will usually have suffered many years of exclusion and trauma. As such, they employ a trauma-informed approach- working at the client's pace and seek consent to address risk and the person's needs mindful of the person's priorities. They understood that statutory partners would not always have this luxury, as their legal obligations are to reduce imminent risk and demand for support outstrips available resource. In discussion the practitioners wished to see opportunities for greater flexibility, so that social care worked alongside voluntary

sector and advocacy as trusted assessors. Social care practitioners spoke of previous cases where they had worked with voluntary sector and social prescribers within GP practices to complete assessments of need (via supported self-assessment). They also explained they make daily use of the risk profile BRAG system introduced within ICT since Sally's death to identify those who require additional support to engage with assessment or safeguarding processes. They confirmed that those risk profiles received managerial oversight, but were less clear how this informed decision making in respect of s42 safeguarding adults processes.

System finding:
A review of Sally's case records provides numerous examples of agencies sharing concerns of her ability to stay safe and of good communication to respond to assaults and health crisis, but not through the s42 safeguarding process. There was some understanding of why she was resistant to social care input, but little exploration of why she failed to attend health appointments or follow up with referrals to services.

The new models (Live Well and SSP's Welfare and Safety Plans) offer a more systematic approach to understanding how best to communicate with and engage adults with additional needs who are at high-risk (either due to external barriers to accessing support due to coercive domestic abuse or criminal exploitation or lack executive capacity). But for these to have maximum impact, SSP partners will need to consider how to embed communication plans across health, housing, social care and criminal justice agencies and identify how the existence of such plans can be easily identified by practitioners e.g. through the universal care plan. SSP partners will also need to agree how to provide oversight of the effectiveness of communication plans in reducing risk and maximising engagement. Recommendation 2 relates to these findings.

KLOE 3: How adept are systems in Swindon at addressing intersectionality of complex trauma, addiction, domestic abuse and exploitation over a significant period of time?

4.25. Within academic research, policy and best practice guidance several terms are used to describe individuals at higher risk of poor outcomes often associated with multiple, complex needs such as Sally experienced. This report, uses the term 'multiple disadvantage' as it is defined by the 'Making Every Adult Matter' approach.[21] Previous research has detailed the higher prevalence of abuse experienced by adults experiencing multiple disadvantage and provided system analysis for how this should be addressed.[22]

4.26. The Gender Matters report (2020) explored the ways multiple disadvantage (including trauma, domestic abuse, mental and/or physical ill health and either homelessness or substance misuse) impacts women differently. The report noted the degree to which violence and abuse in the home are frequently ongoing facts of life, from childhood onwards for many women with multiple disadvantage. Their research estimated 1.1 million adults (the majority women) experienced violence and abuse, mental ill health, substance misuse and homelessness during their adult life. Approximately 17,000 (70% women) experience all four domains at the same time and a substantial proportion of those with the most complex combinations of multiple disadvantage had, like Sally, lost children to the care system. The report also highlighted social isolation is six times more prevalence for those with most complex combinations of disadvantage than for the general population. For the groups facing the most complex combinations of disadvantage, the rates of disability are six to eight times higher than those not reporting any disadvantage. The prevalence of physical disability almost always increases as the count of domains of disadvantage increases. There is also a very clear concentration of people affected by more complex combinations of domains of disadvantage in deprived neighbourhoods.

4.27. Home office data published in 2023 saw the highest recorded domestic abuse crimes reported in the area. In addition, census data indicate a rising population who identify as disabled within Swindon.[23] Local safeguarding data confirms that self-neglect has increasingly (since 2017) been a primary type of risk, whilst financial abuse (were exploitation is most commonly recorded) has persistently been the most prevalent type of abuse in the area. This would indicate that the intersectionality of issues

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[21] as detailed at: **http://meam.org.uk/multiple-needs-and-exclusions/**. Previous research has detailed the higher prevalence of abuse experienced by this cohort and provided system analysis for how this should be addressed.

[22] For example, 'The Knot' (2021) Lankelly Chase and Revolving Door agency available at: https://revolving-doors.org.uk/knot-responding-poverty-trauma-and-multiple-disadvantage/ and Hard Edges report (2015) available at: https://lankellychase.org.uk/publication/hard-edges/

[23] 6.9% of the population are disabled and limited a lot, 10% are disabled and limited a little, 4.8% reported very bad or bad health

identified in Sally's case is increasingly. Practitioners confirmed during discussions with the reviewer that this level of complexity within safeguarding enquiries is now common.

4.28. Changes to the s42 process to introduce a daily safeguarding hub which reviews a daily close concerns list should now identify if repeated safeguarding concerns have been closed without contact with the adult or evidence of action taken to reduced risk. This would not have provided a 'failsafe' in Sally's case as the three referrals to SBC raising safeguarding risks were spread over 3 years. It is unclear why the most recent referral (March 2023) concluded with no further action after she had not returned calls and why consideration was not given to more assertive outreach, invoking the self-neglect procedure or escalating to a multi-agency risk panel.

4.29. In conversation with the reviewer, practitioners spoke of a few panels where complex cases associated with multiple disadvantage can be discussed, for example MARAC, CMARAC, MACE and MAPPA. Each has a separate referral process and criteria. They confirmed that SBC's adult social care department are represented at those meetings so should be able to identify s42 safeguarding duties. However, they also commented that it wasn't always easy to find out what actions came from those meetings or ascertain if risk was reduced for the adult. Some commented that it sometimes felt that difficult cases were 'dumped' with those panels after usual referrals routes had not shown any positive impact on risk.

4.30. SBC's safeguarding practitioners explained they would not usually have information about what was decided at those meetings and may not be aware that cases had been discussed. They accepted this could lead to duplication with their efforts or, more worryingly, adults at risk falling between panels and alternative risk management processes so risks are not addressed. They spoke of the value of multi-agency working to support adults who experience multiple disadvantage, explaining that rarely will one practitioner have the expertise or legal powers to adequately understand the totality of the person's needs, risks they face or have the powers to remove risk solely. They felt being able to track a person though multi-agency panel processes would support improved outcomes. Since Sally's death MARAC have changed their procedures so that they do now have an action tracker. In addition, The Community Safety Partnership are working with panel chairs to improve communication to reduce the risk of duplication.

System finding:
Presently it is difficult to extrapolate the prevalence of multiple disadvantage in Swindon from current data sources. There are no agreed measures currently collected by SSP that would enable strategic planning to decide how best to allocate resources to mitigate additional risks associated with multiple disadvantage or inform wider system reform or service design. Better understanding of the prevalence of multiple disadvantage and more sophisticated impact analysis of service delivery changes should enable reduce duplication and manage demand more efficiently whilst achieving better outcomes for adults at risk.

There are opportunities for SSP to replicate procedural changes introduced by MARAC (to track action outcomes) across all risk management processes and agree a reporting mechanism so they have strategic oversight of actions progressed, challenges or barriers for operational practice and an impact analysis of outcomes for adults at risk. Recommendations 2 and 3 relates to these findings.

KLOE 4: Are practitioners confident to use local and national tools/ best practice briefings to work with people at risk of exploitation, especially cuckooing?

4.31. Research into preventing cuckooing victimisation[24] identified primary targets for cuckooing perpetrators are those who suffer from alcohol or drug dependency, physical disability, mental health or learning disability, frequently they live in socially deprived neighbourhoods. In addition, numerous other risk factors include history of care, present or prior neglect, physical or sexual abuse, financial or housing insecurity or homelessness, social isolation and/or lack of support network, neurodiversity or brain disorder and connections to other vulnerable groups or those involved in street gangs or county lines activity. Many of these indicators of multiple disadvantage featured in Sally's experience.

[24] Undertaken by Dr Laura Bainbridge and Dr Amy Loughery University of Leeds, 2024, available at: https://essl.leeds.ac.uk/downloads/download/244/understanding-and-preventing-cuckooing-victimisation-dr-laura-bainbridge-and-dr-amy-loughery-university-of-leeds

4.32. This research also highlights the challenge identifying cuckooing situations as Organised Criminal Groups [OCGs] usually avoid drawing attention to themselves, often they have 'befriended' the victim and have honed manipulation skills over time resulting in a complex interpersonal relationship whereby the victim may be unaware they are exploited and speak of 'friends'. They are therefore usually reluctant to engage with police and safeguarding agencies either because they don't want to undermine what they perceive as a relationship, or they fear retribution or both. Again, this featured in agencies attempts to engage with Sally in response to exploitation risks. The police reported significant attempts to check on Sally's wellbeing after the closure orders were made in March 2022, but that she requested they stop attending her home. Shortly before her death, Sally also contacted police to alert them a friend had borrowed her bankcard and taken £3.20 without permission. The initial call handler noted she was registered disabled and had a previous warning flag for vulnerability but concluded she was '*not vulnerable in relation to this incident*'[25]. The call received oversight from an investigator and the investigating officer's supervisor gave directions to ensure all relevant safeguarding actions had been completed. The investigating officer made several attempts to call and wrote to her to ask for further information, but she did not respond and (understandably, given the sums involved) it was deemed not in the public interest to conduct more assertive investigation or contact with her.

4.33. Rose Broad research into multi-agency responses to cuckooing[26] explored common barriers to developing a 'community of practice'[27]. Her work highlighted that although police, housing, health and social care all had underlying public sector duties to safeguarding and promote equality of opportunity, the agencies have differing priorities when responding to cuckooing. Police will, understandably, focus on criminal responses, using civil powers to address immediate risk as they did in Sally's case in 2022. Housing staff's priority is the impact for other residents, reflecting the limitations of their powers only to intervene if behaviours have wider public health or safety ramifications. Social care participants within her research also reported challenges where the perception was one of a dysfunctional relationship rather than a clear victim- offender paradigm. Broad identified that the differing priorities could make it difficult to establish a community of practice as it wasn't always apparent who should take ownership of the problem and who should be part of any community of practice or team around the person. So, whilst police or community safety officers may lead on immediate risk reduction strategies- securing civil orders or criminal sanctions, there is no clearly established pathway to ensure follow up from other welfare agencies to enable the adult to recover and remain safe from further abuse. Given the high prevalence of poor mental health for victims of cuckooing, the research highlighted significant gaps nationally in securing specialist mental health input unless there was an immediate crisis. Finally the research found limited shared activities (opportunities for knowledge exchange, sharing skills). As a consequence, much of the good practice that had developed had done so informally. Her research concluded this '*rests on people instead of processes'*. Practitioners involved in Broad's research reported that unless clear safeguarding concerns had been identified (and the s42 processes employed) information sharing was difficult. Others also reported perceptions that the criteria for eligibility under s13 Care Act 2014 would not apply meant that too often victims of cuckooing fell through '*gaps of statutory procedure*'.

4.34. This resonant with Sally's experience, police were able to quick secure civil orders to prevent anyone but her living in her property. However, securing longer-term support to help her address presentations of poor self-care, manage her health conditions more effectively and protect herself from ongoing abusive associations proved much more difficult. Whilst agencies identified safeguarding concerns and raised concerns that she was not managing many activities of daily living or her health need, this was not interpreted as requiring ongoing social care input. Practitioners involved in this review commended the work of Medaille Trust in Swindon who can support statutory partners regarding the risks associated with modern slavery.

4.35. Both the police and GWH reported Sally remained at risk without additional support and that she was '*very scared about going home.*' Professional overoptimism may have played a part in her discharge from outpatients which left the onus on Sally to re-initiate contact with surgical services (via her GP) and pain management (via the service secretary) despite knowledge of her psychological, mobility and pain management needs (excessive opioid use and history of heroin use).

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[25] Taken from the police call log.
[26] This research focused on processes and practice across Greater Manchester Authority, and reported at a Symposium on the 03.05.23 and available at: https://essl.leeds.ac.uk/downloads/download/217/communities_of_practice_in_multi-agency_responses_to_cuckooing
[27] Defined by Wenger (2009) as 'groups of people who share a concern or passion for something they do and learn how to do it better as they interact regularly'.

4.36. Practitioners explained that there are opportunities to draw on existing and new data sources to better understand cuckooing prevalence in Swindon. SBC's community safety and children services' opal team already have data which provides a picture of the hotspots. So too do the police teams tasked with responding to this risk (Sentinel[28] and neighbourhood teams), but this could be enhanced by incorporating information from neighbourhood housing officers, community safety, adult social care and multi-agency panels so it includes data on the prevalence of multiple disadvantage and other indicators of cuckooing detailed at above. In addition, raising wider awareness of the indicators of cuckooing together with support available could empower stronger links to build a community of practice across Swindon. Practitioners involved in this review agreed strongly that adopting more widely the 'making every contact count' approach[29] already advocated by SSP agencies would be hugely beneficial. They believed cuckooing was significantly underreported in the area, but felt such an approach would build on the excellent knowledge base already provided by the SSP on their website[30].

4.37. Mindful of the significant challenges faced by many relevant agencies, practitioners and panel members involved in this review felt it would be important that any new multi-agency approach to cuckooing should initially be closely aligned to the s42 processes in recognition that most victims will have care and support needs even if those are not being actively met by SBC's adult social care. They felt that the s42 process was well established to provide clear managerial and strategic oversight by SSP through data analysis. In addition, there were already established escalation protocols in place if actions were not having a positive impact on risk or the person's wellbeing.

System Finding:
Responses to cuckooing are fragmented, reactive and too heavily focused on criminal or civil sanctions. For Sally this meant that too little regard was given to supporting her longer-term recovery and wellbeing in a trauma-informed way. This increased the risk of re-victimisation and resulted in a deterioration in her health and escalation of her social care needs.

Whilst SSP's website already provides guidance to support practitioners respond to adult exploitation, this could be further enhanced with a 'making every contact count' briefing specific to cuckooing and developing a risk profile tool which should include opportunities to work across risk management forums, so, for example, if issues are identified within MARAC meetings these can inform the s42 enquiry process. SSP are currently developing an all-age exploitation strategy so are in a strong position to build a strong community of practice in response to cuckooing. This should seek to agree new pathways and monitoring arrangements to support the development of a culture within the partnership of shared ownership of responses that disrupt perpetrators and support victim's recovery. Recommendations 2 and 3 relates to these findings.

Recommendations

Prior to completing the report, the reviewer met with SSP support unit to better understand how partners were taking forward recommendations and actions to address learning from recently published local reviews. In light of their current workplan, the reviewer recommended SSP focus on the following recommendations to compliment previous recommendations and further improve responses to cuckooing.

Recommendation 1: SSP should review the e-guidance reporting to ensure that concerns can be lodged, even if all the information is not known by the referring agency.

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[28] Wiltshire police report: '*The Sentinel team conduct proactive investigations into child sexual exploitation, adult sexual exploitation, modern slavery and human trafficking and wider exploitation of vulnerable persons. The team provide a dedicated resource, with training and knowledge in these areas, to protect vulnerable people from harm, increase prosecution rates and increase opportunities to dismantle harmful organised criminal groups. The Sentinel Team will develop intelligence leads to establish proactive operations in exploitation investigations, to disrupt and prosecute perpetrators whilst engaging with, and supporting, the victims of these crimes through the criminal justice system. This will be achieved by specialist knowledge of exploitation investigations, tactics and the continuity in victim support, and utilising the specialist skills of our local authority, other agencies and voluntary groups where necessary.*
The Sentinel Team will provide specialist prevention support around child exploitation (criminal and sexual), adult sexual exploitation and missing persons. Specialist officers will provide tactical support to the wider force and work with our partners to develop to reduce risk and safeguard adults and children vulnerable to exploitation. Missing person support officers will provide support to missing person investigations with a focus on the reduction of repeat missing episodes and recognise and mitigate risk from exploitation.'

[29] This approach draws on public health data to support improvements on health and wellbeing detailed at: https://www.hee.nhs.uk/our-work/population-health/our-resources-hub/making-every-contact-count-mecc
[30] See https://safeguardingpartnership.swindon.gov.uk/info/20/community_safety/104/exploitation_of_adults

Recommendation 2: SSP should formalise reporting by multi-agency panels to capture data regarding the prevalence of multiple disadvantage (including trauma, addiction, domestic abuse and exploitation) and report of outcomes using the MSP measures[31]. This should also include reporting on the use of engagement plans to evidence reasonable adjustments are made by services in line with the public sector equality duty for adults with complex needs. SSP partners could audit closed referrals, particularly where there is professional disagreement or escalation to ensure decision making is consistent with NICE guidance and safeguarding best practice briefings. This will enable partners to provide SSP with assurance of safe systems.

Recommendation 3: Partner agencies should work with SSP to develop communities of practice in response to cuckooing. To enable a whole system approach, this should focus on:

- Direct practice: Providing MECC briefings which highlight indicators for frontline practitioners and give details of s42 reporting pathways and local support available (including from voluntary sector agencies). Neighbourhood policing, housing officers, social prescribers and community pharmacists, district nursing and social care triage staff should be targeted for training opportunities including induction training, so the burden does not continue to fall on emergency responders.
- Team around the person: Linked to recommendation 2 and building on the Living Well pilots and Safety and Wellbeing plans, primary and secondary health leads should explore how health inclusion initiatives to address health inequalities could support identification of those at higher risk due to multiple disadvantage and ascertain adults at risk who require communication plans to alert statutory services if they are at imminent risk. All SSP partners should identify increased opportunities for assertive outreach to adults at high-risk of exploitation, but specific focus should be given to capacity within LiFT, SIS and ICT to provide this. SSP partners should also identify champions within their organisation who have support wider dissemination of good practice in response to cuckooing.
- Organisational support: Further clarification within self-neglect and safeguarding adults' policies (both SSP and partners internal policies to ensure consistency) about when concerns should trigger multi-agency consultation and when formal s42 enquiries should be undertaken in respect of cuckooing and/or self-neglect would enable consistent decision making. In addition, the adult MASH should consider hosting a case action tracker and monitor through a monthly panel to review cuckooing s42 enquiries and escalate cases that have not received support to assess capacity, their needs or received support to address psychological or practical support needed to stay safe.[32] Regular membership of that panel should include primary care leads, neighbourhood housing, police and community safety and operational social care representative who are able to commit their agencies to complete necessary actions and provide relevant data/ case information.
- Governance: SSP partners should agree any information sharing protocols that might be necessary to enable the cuckooing panel to operate effectively. SSP should also agree oversight and assurance reporting mechanisms from multi-agency panel processes report regularly to the SSP executive so that strategic leaders can build an understanding of the severity and prevalence of exploitation (especially cuckooing) over time.

[31] This could be easily achieved by recording cuckooing concerns via s42 processes as this already records KPIs required by NHS Digital for the safeguarding adults collection

[32] SSP partners are currently developing a panel process to explore high risk exploitation cases so arrangements to track cuckooing cases and report on short and longer-term outcomes should form part of those discussions.